UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Remicade (infliximab) **for Chrohn's Disease**

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#_____Ext. and options:_____Fax#_____

Physician's NPI:_____

Diagnosis_____Current wt_____mg/kg_____

Administered every_____weeks starting (date)_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO: 801-536-0477

CRITERIA:

- Age requirement: 6 years old and older
- Diagnosis of moderate to severely active Chron's Disease
- Has failed conventional therapy (i.e. 5-aminosalicylates, antibiotics, MTX, 6-mercaptopurine, azathioprine, corticosteroids, budesonide)
- Negative TB skin test or history of treatment for latent TB infection
- Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- Remicade may not be given with other biologic agents such as Interferon, experimental medications or combinations.
- Remicade may not be given with Enbrel or Kineret.

INFORMATION:

To be given in clinic setting only. Patients on HMO's (except IHC) will have to make arrangements with their HMO for coverage. Provider will bill with J code J1745 and PA number

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

An updated letter of medical necessity or progress notes showing improvement or maintenance.